STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155430	A. BUILDING 00 B. WING	05/26/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
HICKORY CREEK AT ROCHESTER	340 E 18TH ST ROCHESTER, IN46975

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F0000	This visit was for the Investigation of Complaint IN00090339. Complaint IN00090339 - Substantiated. Federal/state deficiencies related to the allegations are cited at F282 and F323. Unrelated deficiencies cited. Survey dates May 24, 25, and 26, 2011 Facility number: 000326 Provider number: 155430 AIM number: 100290770 Survey team: DeAnn Mankell, R.N. Census bed type: SNF/NF: 33 Total: 33 Census payor type: Medicare: 4 Medicaid: 21 Other: 8 Total: 33 Sample: 7 These deficiencies also reflect state findings in accordance with 410 IAC 16.2.	F0000	This Plan of Correction constitutes the written allegation of compliance for the deficiencies cited. However, submission of this Plan of Correction is not an admission that a deficiency exists or that one was cited correctly. This Plan of Correction is submitted to meet requirements established by state and federal law. Hickory Creek at Rochester desires this Plan of Correction to be considered the facility's Allegation of Compliance. Compliance is effective on June 24, 2011.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE

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	Quality review completed 6/1/11 by Jennie Bartelt, RN.			
F0282 SS=D	The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on record review and interview, the facility failed to follow a physician's order for alarm placement for 1 of 5 residents with falls in a sample of 7 (Resident B). Finding include: Resident B's closed clinical record was reviewed on 5/25/11 at 11:30 A.M. Resident B's diagnoses included, but were not limited to, Alzheimer's disease, dementia, hypertension, COPD (chronic obstructive pulmonary disease), paranoia, depression, and dysphagia. Resident B's quarterly MDS (Minimum Data Set) assessment, dated 3/17/11, indicated Resident B was severely impaired cognitively. The assessment indicated Resident B needed extensive	F0282	F282 It is the policy of this facility to provide services which are provided by qualified persons in accordance with residents' written plans of care, including following physician's orders for alarm placement. 1. What corrective action will be done by the facility? Resident B is no longer a resident of this facility. The DON has in-serviced 5/23/11, and will again on 6/15/11, the nursing staff regarding the requirement to know residents who need alarms, check each shift for function and placement of alarm and that alarms must be moved with the resident when repositioned or ambulated. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? For all residents currently using alarms, the type and position of alarm has been re-assessed for	06/24/2011

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	assistance of two to transfer to and from her bed, chair, wheelchair, toilet, and to stand. The assessment indicated she needed extensive assistance of one person to walk. She was assessed as not steady, only able to stabilize with human assistance for balance when standing, walking, turning around and transferring from one surface to another surface, including toileting. She used a wheelchair or a walker while moving through the facility. The MDS indicated she had falls after she had been admitted to the facility, but she had no injuries. Resident B's April 2011 and May 2011 monthly rewritten orders indicated orders first written on 1/24/2011 for "Sensor pad while in bed. Check function every shift. Sensor pad while up in chair. Check function every shift." The nurses' notes indicated on 5/12/11 at 9:00 P.M., "Resident got self up to walk to room without informing staff. Resident fell backwards - hitting head - goose egg noted to back of head.... Assisted up to feet - ambulated rest of way to bed.... send resident to (name) ER for evaluation & treat...." The incident/accident investigation indicated, "The alarm was not in use, and "forgot to put in chair." The prevention		appropriateness. Fall risk assessments have also been completed with revised interventions put into place to meet the assessed needs for fall risk and prevention. In the future, if the DON or designee observes that a resident does not have an alarm applied and in working order, she will act immediately to make sure that the alarm is in place and turned on so that it is in working order. Once she is assured that the resident is safe, she will re-train the staff involved regarding the facility policy and procedure for alarm application and use. She will also render progressive disciplinary action as deemed necessary for continued noncompliance up to, and including, termination. 3. What measures will be put into place to ensure this practice does not recur? The DON or designee will review the application of alarms as part of regular rounds that are done several times a day during her tour of duty. In addition, she will check 3 residents per week to determine consistency of alarm checks, accurate placement of alarms, whether or not the alarms are in working order, and adequacy of fall risk interventions overall. If any issues are identified or observed, the DON or designee will follow up as indicated in question #2. On the week-ends and various shifts, the charge nurse will be responsible for checking the alarms for	

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	was, "Remind staff to use alarm even when transferred (Transfer alarm also)." During an interview with LPN #1, on 5/25/11 at 3:05 P.M., she indicated she had placed Resident B in her chair in front of the nurses' station and gave her a snack. LPN #1 was sitting at the desk charting, but when she looked up the resident was gone. She walked out of the nurses' station through the hall and around the corner, but when she got around the corner, Resident B was falling onto the floor. She said there was no alarm on the resident. The Administrator, who was listening to the interview, indicated this was "human error." This federal tag relates to Complaint IN00090339. 3.1-35(g)(2)		placement and working order, and for adequacy of fall risk interventions until IDT can review. The week-end manager will also check at least 3 residents during their tour of duty for alarm placement and working order.The results of these checks will be brought to the next scheduled morning management meeting that meets at least 5 days a week for review by the interdisciplinary team. Any recommendations made at that time will be followed through by the DON. 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The DON or designee will bring the results of their rounds and resident-specific audits to the monthly QA&A committee for further review & recommendation for process improvement. Any recommendations made will be followed up by the DON who will report the results of the improved process at the next QA&A Committee meeting. The QA&A Committee may stop the specific resident reviews after 90 days when 100% compliance is achieved; however, continued monitoring of the alarm use during rounds will continue on an ongoing basis. Date of Compliance: 6/24/11	

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F0323 SS=G	The facility must ensure that the resident environment remains as free of accident hazards as is possible; and each resident receives adequate supervision and assistance devices to prevent accidents. Based on record review and interview, the facility failed to supervise a resident to prevent falls resulting in skin tears and hematomas for 1 of 5 residents with falls in a sample of 7. (Resident B). At the time of one fall, Resident B's chair alarm was not in place, and she was unsupervised. Injury from the fall required transfer to the emergency room for management of a subdermal scalp hematoma and shoulder contusion with pain. Finding include: Resident B's closed clinical record was reviewed on 5/25/11 at 11:30 A.M. Resident B's diagnoses included, but were not limited to, Alzheimer's disease, dementia, hypertension, COPD (chronic obstructive pulmonary disease), paranoia, depression, and dysphagia. Resident B's quarterly MDS (Minimum Data Set) assessment, dated 3/17/11, indicated Resident B was severely impaired cognitively. The assessment indicated Resident B needed extensive assistance of two to transfer to and from	F0323	F323 It is the policy of this facility to ensure that each resident receives adequate supervision and assistance devices to prevent accidents, including supervision to prevent falls that result in skin tears and hematomas. 1. What corrective action will be done by the facility? Resident B no longer resides in this facility. The DON has in-serviced on 5/23/11, and will again on 6/15/11, the nursing staff regarding the requirement to know residents who need alarms, check each shift for function and placement of alarm and that alarms must be moved with the resident when repositioned or ambulated. In addition, staff will be in-serviced 6/15/11 the need to re-evaluate the resident's fall risk after each fall and to develop/revise existing fall interventions to meet the results of that fall risk reassessment. 2. How will the facility identify other residents having the potential to be affected by the same practice and what corrective action will be taken? For all residents currently using alarms, the type and position of alarm has been re-assessed for appropriateness. Fall risk assessments have also been completed with revised interventions put into place to meet the assessed needs for fall	06/24/2011

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	her bed, chair, wheelchair, toilet, and to stand. The assessment indicated she needed extensive assistance of one person to walk. She was assessed as not steady, only able to stabilize with human assistance for balance when standing, walking, turning around and transferring from one surface to another surface, including toileting. She used a wheelchair or a walker while moving through the facility. The MDS indicated she had falls after she had been admitted to the facility, but she had no injuries. Resident B's April 2011 and May 2011 monthly rewritten orders indicated orders first written on 1/24/2011 for "Sensor pad while in bed. Check function every shift. Sensor pad while up in chair. Check function every shift." The "Fall Risk Assessment" completed on 3/26/11, 4/10/11, 5/12/11, and 5/16/11, indicated a total score of 23 on 3/26/11 and 22 on the last 3 dates. The key indicated "If the total score is '10' or greater, the resident is considered at HIGH RISK for potential falls. Interventions should be initiated immediately & the care plan updated." There was a care plan for the problem of "I am at increased risk for falls. I require a pressure alarm on my chair and on my		risk and prevention. In the future, if the DON or designee observes that a resident does not have an alarm applied and in working order, she will act immediately to make sure that the alarm is in place and turned on so that it is in working order. If the Administrator, DON, or other IDT member observes that any fall intervention is not in place as designated on the resident's care plan, he/she will immediately intervene with the staff and resident to make sure that the resident is safe. Once the resident's safety is assured, the Administrator or DON will review the facility policy on utilizing interventions designated in the residents' care plans, including the use of alarms, with the staff involved. In addition, progressive disciplinary action will be utilized for continued instances of noncompliance with facility policy. 3. What measures will be put into place to ensure this practice does not recur? An identifier will be used to let staff know who is at risk of falling. Identifier will be placed on name tag at door. Staff will be in-serviced on the identifier and who is responsible for placing identifier after fall risk assessment is completed. Current residents' fall risk assessments have been reviewed to assure that the assessment is accurate and consistent with each resident's current status. The care plan and CNA assignment	

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	bed" dated 11/10/2010 with additional hand written dates of 1/10/11 and 3/23/11. The interventions included, but were not limited to, "2. My room will be kept free from clutter. 3. My call light will be within reach. 4. My rollater walker will be kept in my reach. 5. I will call for assistance if needed. 8. My alarms will be checked each shift." On 3/7/11 additional interventions were added of "11. Fall Risk Assessment. 13. Lowered bed. 14. Non skid materials in chair. 19. 2 staff to assist to toilet. 20. Medicine changed." The nurses' notes indicated on 4/10/11 at 11:00 A.M. "Called to room as resident got up to get walker to go to bathroom. When reaching for walker, resident tripped on floor mat, falling into walker. Received 6 X 5 cm. (centimeter) Lt (light) purple raised area to (L) (left) forehead and 1.7 X 0.7 cm. skin tear to (L) forearm.... c/o slight headache. Neuro checks initiated... Sensor pad was on and alarming at the time. Then ambulated with assist to bathroom...." The incident/accident report dated 4/10/11 indicated "alarm sounding - resident walking to walker & tripped on floor mat causing her to fall into walker bumping head on walker receiving 6 X 5 cm. raised area to (L) forehead and 1.7 X 0.7 cm skin tear to (L) forearm. No other injuries		sheets have been updated to include the appropriate fall interventions determined by the IDT as a result of the most recent fall risk assessments. The DON or designee will review the application of alarms as part of regular rounds that are done several times a day during her tour of duty. In addition, she will check 3 residents per week to determine consistency of alarm checks, accurate placement of alarms, whether or not the alarms are in working order, and adequacy of fall risk interventions overall. If any issues are identified or observed, the DON or designee will follow up as indicated in question #2. On the week-ends and varioius shifts, the charge nurse will be responsible for checking the alarms for placement and working order, and for adequacy of fall risk interventions until IDT can review. The week-end manager will also check at least 3 residents during their tour of duty for alarm placement and working order.The results of these checks will be brought to the next scheduled morning management meeting that meets at least 5 days a week for review by the interdisciplinary team. Any recommendations made at that time will be followed through by the DON. If a resident experiences a fall, the investigation of the incident, as well as review and updating of the resident's assessment and care	

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	noted at this time able to move extremities per usual...." The section for "Additional comments and/steps to prevent re-occurrence:" was blank. The fall investigation report dated 4/10/11 indicated the sensor pad alarm was in use and it sounded. The resident account of the incident was "getting walker to go to bathroom." The conclusion was the fall was caused by the resident "got up unassisted." The prevention was "pick up floor mat p (after) resident gets OObed (out of bed). During an interview with the LPN #1, on 5/25/11 at 3:00 P.M., who wrote the notes and did the initial assessment, she indicated Resident B had been sitting in her recliner at the foot of her bed, she got up and walked to the head of her roommate's bed where her walker was sitting. On her way she tripped on her roommate's mat on the floor. She indicated the roommate was in bed at the time. Resident B did not have a mat on the floor. She further indicated the floor mat had been taped to the floor. She did not know why Resident B's walker was on her roommate's side of the bed. She indicated Resident B was not always steady on her feet, even with the walker, and needed one person to walk with her.		plan will be reviewed at the next scheduled morning management meeting that occurs at least 5 days a week. The IDT will evaluate the fall interventions & update the care plan. Staff is notified by the Administrator and DON whenever a new intervention is implemented – the intervention is also placed on the CNA assignment sheet. Falls and interventions are also reviewed at the weekly Standards of Care meeting, which is attended by the IDT. 4.How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The Administrator and DON will bring the results of the monitoring rounds done by the nursing staff and IDT members to the Standards of Care meeting each week and to the monthly QA&A Committee meeting for review and recommendations in process improvement. Any recommendations made will be followed up by the Administrator and DON who will report the results of the improved process at the next QA&A Committee meeting. This practice will continue on an ongoing basis. The DON or designee will bring the results of their rounds and resident-specific audits to the monthly QA&A committee for further review & recommendation for process improvement. Any recommendations made will be followed up by the DON who will	

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	There were no new interventions added to the care plan after this fall. The nurses' notes indicated on 5/12/11 at 9:00 P.M., "Resident got self up to walk to room without informing staff. Resident fell backwards - hitting head - goose egg noted to back of head, Ice applied. Neuro checks initiated - within parameters for resident. Assisted up to feet - ambulated rest of way to bed.... send resident to (name) ER for evaluation & treat...." The ER history and physical for 5/12/11 indicated "Fall (without loss of consciousness) with resultant 3 cm left occipital parietal subdermal scalp hematoma and left shoulder contusion with mild pain.... Patient already is on a Duragesic patch for pain...." The incident/accident investigation indicated, "The alarm was not in use," and "forgot to put in chair." "Resident in front of the nurses' station eating snack. Got up and started walking to room. Fell over backwards hitting head - goose egg - hematoma to back of head...." The "Additional comments and/or steps taken to prevent re-occurrence" section of the report indicated, "Make sure alarm on & functioning." The conclusion was "res was agitated & got up on own & fell." The prevention was "Remind staff to use		report the results of the improved process at the next QA&A Committee meeting. The QA&A Committee may stop the specific resident reviews after 90 days when 100% compliance is achieved; however, continued monitoring of the alarm use during rounds will continue on an ongoing basis. Date of Compliance: 6/24/11	

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	alarm even when transferred (Transfer alarm also)." During an interview with LPN #1, on 5/25/11 at 3:05 P.M., she indicated she had placed Resident B in her chair in front of the nurses' station and gave her a snack. LPN #1 was sitting at the desk charting, but when she looked up the resident was gone. She walked out of the nurses' station through the hall and around the corner, but when she got around the corner, Resident B was falling onto the floor. She said there was no alarm on the resident. The Administrator, who was listening to the interview, indicated this was "human error." The screen completed on 5/13/11 for physical therapy indicated, "Pt. didn't have chair alarm in place. Pt. not therapy appropriate." There were no new interventions added to the care plan after this fall. The nurses' notes indicated on 5/16/11 at 7:45 A.M., "Chair alarm sounding. When writer responded to alarm - found resident lying on floor in room (number) with head up against night stand. Voicing c/o headache. Noted to have 1.5 cm diameter raised area to back of head. Attempted to apply ice but resident refused."			

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The incident/accident report dated 5/16/11 indicated "Alarm sounding - resident got up and ambulated to room (number) (the room next to hers). Found lying on back with head against night stand. 1.5 cm diameter raised area noted to back of head...." The section for "Additional comments and/or steps taken to prevent re-occurrence" was blank.

The fall investigation report dated 5/16/11 indicated the resident's alarm was on and sounding. The conclusion of what caused the fall was "Res. continues to get up on own before staff can reach her." The section for "How will this incident be prevented from occurring again? had an intervention of "attempt to involve in more activities."

During an interview with LPN #1 on 5/25/11 at 3:07 P.M., she indicated the resident had been sitting in her wheelchair in front of her room waiting to be taken to the Dining Room for breakfast. She said she was passing trays and the CNA's were in the back of the building on the other side when she heard Resident B's chair alarm, but by the time she was able to get to her, Resident B had walked from in front of her door into the next resident's room and had fallen. She indicated she did not know why the CNAs who had

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	placed her in her wheelchair had not moved her to the dining room. There was a care plan for the problem of "I am at increased risk for falls. I require a pressure alarm on my chair and on my bed" had an a new intervention added on 5/16/11 of "Encourage & provide activities, magazines, pictures, snacks, drinks, etc." During interivew on 5/25/11 at 3:40 p.m., the DON indicated she thought the resident just needed to be busy to help prevent the falls. Review of the policy for "Fall Prevention Program" dated 11/02 with the latest revision date of 7/09 indicated "It is the policy of this facility to identify residents at risk for falls and to implement a fall prevention program to reduce the risk of falls and possible injury." The procedure included, but was not limited to, "...The Interdisciplinary Team (IDT) will review the resident's fall risk prevention plan no less often than quarterly, as part (sic) the care conference.... the plan will be reviewed and modified as needed, after each fall to make sure that the interventions are as current as possible....The DON will conduct the investigation and complete the back side of the Fall Investigation Report			

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	form....The DON will review the Fall Investigation Report with the Interdisciplinary Team at the next scheduled morning management meeting to develop a fall prevention plan, including the development of new interventions or revision of existing ones. If staff training is identified as a need, the training session(s) will be scheduled at that time...." This federal tag relates to Complaint IN00090339. 3.1-45(a)(2)			
F0514 SS=D	The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete; accurately documented; readily accessible; and systematically organized. The clinical record must contain sufficient information to identify the resident; a record of the resident's assessments; the plan of care and services provided; the results of any preadmission screening conducted by the State; and progress notes. Based on record review and interview, the facility failed to have a complete record	F0514	F 514	06/24/2011

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	155430	A. BUILDING 00 B. WING	05/26/2011

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	the care provided to a resident with a low oxygen saturation level for 1 of 1 resident on oxygen therapy in a sample of 7 (Resident B). Finding include: Resident B's closed clinical record was reviewed on 5/25/11 at 11:30 A.M. Resident B's diagnoses included, but were not limited to, Alzheimer's disease, dementia, hypertension, COPD (chronic obstructive pulmonary disease), paranoia, depression, and dysphagia. Resident B's April 2011 and May 2011 monthly rewritten orders indicated orders first written on 10/05/2010 for "O2 (oxygen) @ 2 L (liters) via nasal cannula as needed and DNR (do not resuscitate)." There was an order dated 02/07/2011 for "Comfort care only." Nurses' notes indicated: 5/18/11 5:45 A.M. ".... tx (treatment) given for SOB (shortness of breath) O2 (oxygen) sat (saturation) 65% on RA (room air)...." 5/18/11 9:00 P.M. "68% RA. RR (respiratory rate) 28...." RN #1 was interviewed on 5/25/11 at 2:45 P.M., and she indicated she had not called		It is the policy of this facility to maintain clinical records on each resident in accordance with accepted professional standards and practices that are complete, including assuring a complete record regarding care provided to residents with low oxygen saturation levels. 1.What corrective action will be done by the facility? Resident B is no longer a resident of this facility. Nursing staff will be in-serviced 6/15/11 to obtain baseline oxygen saturation parameters from the physician when obtaining oxygen orders. In addition, the nurses have been in-serviced on the need to document all notifications of physicians, as well as the physician's response to their notification. They have also been in-serviced on documenting residents' refusal of services, medications, or treatments each time that this occurs. 2. How will the facility identify other residents having the potential to be	

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	the physician about the low oxygen saturation levels nor had she started the oxygen because the resident didn't want the oxygen on and would take it off. She indicated she had not charted the resident's refusal of the use of the oxygen. During an interview with the Administrator on 5/26/11 at 1:25 P.M., she indicated the physician knew of the resident's low oxygen saturation levels and he didn't want oxygen given. She provided a Progress Note written on 5/17/11 (a day before the nurses' notes for the low O2 saturation levels) indicating he was wanted to "... continue Duragesic patch (a patch with medication to control pain), Roxanol (a narcotic to control pain) to treat pain and suppress oxygen hunger." She further indicated he knew Resident B had a low oxygen saturation levels, because he called the facility everyday about his residents. The clinical record lacked a physician note related to the resident's low oxygen level. 3.1-50(a)(1) 3.1-50(a)(2) 3.1-50(f)(5)		affected by the same practice and what corrective action will be taken? No other resident has been affected. Each resident with PRN oxygen order was assessed for respiratory issues during survey. Oxygen saturations were taken, finding all within normal range. In the future, if the DON finds that there are no specific oxygen parameters for oxygen administrations when a resident has a PRN oxygen order, she will make sure that the physician is notified as soon as possible to obtain those parameters. Also, if she finds that documentation of physician notification or residents' refusal of services, medications, or treatments is not completed, she will make sure that the resident is safe and taken care of appropriately. Once both of these situations are addressed, the DON will review and re-inservice the	

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			nurse(s) involved in the facility policy and expectation for these situations. She will also address the noncompliance with progressive disciplinary action. 3. What measures will be put into place to ensure this practice does not recur? When baseline parameters are received from the physician for oxygen saturation levels, the nurses will follow them when treating the resident and notifying the physician. In the event that no baseline oxygen saturation level has been established, the nurse will contact the physician whenever the oxygen saturation level drops below 90%. The DON will review the 24 hour report and focus charting at least 5 days a week as part of her tour of duty. If she identifies any issue regarding the administration of oxygen for a resident or a lack of completion in documentation of physician notification or a	

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			resident's refusal of treatment or services, she will address the situation immediately as indicated in question #2. She will bring the results of her review to the morning management meeting that occurs at least 5 days a week with the interdisciplinary team for further review and recommendations. The IDT will evaluate the situation and provide any other interventions that are believed to be necessary to better meet the need of the resident involved. Staff will be notified by the DON whenever a new intervention is implemented – the intervention will be placed on the CNA assignment sheet as well. 4. How will corrective action be monitored to ensure the deficient practice does not recur and what QA will be put into place? The DON will bring the results of her reviews to the monthly QA&A committee for	

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			recommendations for process improvement. Any recommendations made will be followed up by the DON who will report the results of the improved process at the next QA&A Committee meeting. This will continue on an ongoing basis. Date of Compliance: 6/24/11	